**Dr G Balachandran**

**Ms Annabel Bruce**

**THE MEDICAL CENTRE**

**45 DONCASTER DRIVE NORTHOLT MIDDLESEX UB5 4AT**

**TEL: 0208 864 8133 FAX: 0208 422 8040**

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| --- |
| **New Patient Questionnaire** |

This new patient questionnaire will provide us with preliminary information about your health and please help us by completing this questionnaire.

Thank You

**Please Write Clearly in Capital Letters**

|  |  |
| --- | --- |
| **Title** |  |
| **Forenames** |  |
| **Surname** |  |
| **Previous Surname** |  |
| **Date of birth** |  |
| **Male/Female** |  |
| **Marital Status** | Single /Married /Divorced / Widowed |
| **Telephone Numbers: Home** |  |
| **Mobile** |  |
| Work |  |
| **Email address:** |  |
| **Consent to receive SMS messages** | yes/no |
| **Sharing Consent** | yes/no |
| **Are you a Carer**? Do you look after someone who is ill/frail/disabled etc?  If yes,Please state | yes/no *(See Note 1 on page 2)* |
| **Ethnic Group**: Please state |  |
| **First language**: Please state |  |
| **Next of Kin:** Please state |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | **Previous Medical History:** | | Do you suffer from **any Food or Drug allergies**? Yes / No  Please state: | | Have you ever suffered from any of the following? (Please circle) | | Asthma / Glaucoma / Cancer / High Blood Pressure / Diabetes  Heart attack / Epilepsy / Hypothyroidism / Stroke | | Please state Any other Medical Conditions you have suffered: |  |  | | --- | | Do you drink **alcohol?** Yes / No | | If yes, how much on average do you drink in a week? Please complete questionnaire on page 3 | | Pints:  Glasses of wine:  Shorts: | | Have you **ever smoked?** Yes / No | | Do you **currently smoke?** Yes / No *(See Note 2 on page 2)* | | If yes, how many cigarettes/cigars do you smoke a day?  How long have you been smoking?  If you have ever stopped, when? | |

|  |  |
| --- | --- |
| **Height** | **Weight** |
| Do you take any form of **regular exercise**? | Yes / No |
| If yes, is it … Light Moderate Heavy | Light Moderate Heavy |
| Have you had a **Tetanus or Polio booster** in the last 10 years | Yes / No |
| If yes, When did you have the booster? |  |
| Do you take **any regular medication?** | Yes / No |
| If yes, please list them on a separate sheet or attach a **copy of your Repeat medication list** from your previous doctor |  |
| Do you have any **family history** of illness, like, heart disease/cancer etc.?  If Yes- please state which family member (maternal/paternal) | Yes / No |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Females Only**   |  |  | | --- | --- | | Have you had a **smear test in the last 3 years?** | Yes / No | | If yes, was the result normal? | Yes / No | | Have you had any **breast screening (mammogram) in last 3 years** | Yes / No | | **Are you pregnant/or have just had a baby** | Yes / No | |

**Please advise us of any other important medical information.**

*Note 1***: If you are a carer:** please make an appointment with our Health Care Assistant for a general health checkup and it is also advised that you have an annual flu vaccination. Please make an appointment during the annual flu vaccine campaign which begins in September.

*Note 2:* If you would like to **STOP smoking** please book an appointment with the Practice Nurse.

**Thank You**

**Signature: Date**:

**Fast alcohol screening test (FAST)**

FAST is an alcohol harm assessment tool. It consists of a subset of questions from the full alcohol use disorders identification test (AUDIT). FAST was developed for use in emergency departments, but can be used in a variety of health and social care settings.

Could you please complete this questionnaire and hand over this document to a member of reception staff? Thank you

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your Score** |
|  | **0** | **1** | **2** | **3** | **4** |  |
| How often have you had 6 or more units if female,  or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |  |
| **Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).** | | | | | |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | Never | Less than monthly | Monthly | Weekly | Daily or almost Daily |  |